Sliced Down to the Moral Backbone?

Ethical Issues of Structural Reforms in Healthcare Organizations

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Throughout the 1990s we have experienced a wave of healthcare reforms. This article assesses central issues in policy and systems as well as structural changes in the provision of services against the ethical principles of non-maleficence, beneficence, autonomy and justice. The lack of universal coverage is a serious threat to a just and equitable healthcare system. Doubts have recently been expressed concerning the benefits of competition, even within a regulated internal market. Service reorganization raises fewer ethical concerns. Cost-cutting has followed in the aftermath of the financial crises of the early 1990s, and when carried out by restricting access, it may be in conflict with principles of justice and autonomy. Mere cost-cutting does not, however, establish a viable political agenda. It is argued that changes in healthcare need to be implemented in a way that does not lead to conflict with professional values.

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Healthcare reform swept over the Western Hemisphere in the beginning of the 1990s. Prime Minister Margaret Thatcher's major overhaul of the British National Health Service (NHS) raised great interest, and coincided in time with ambitious reform plans in The Netherlands, Sweden and Finland. Some years earlier, the traditionally strong role of the centre in the Spanish national healthcare system had started to diminish in pace with the growing autonomy of the regions. In Italy, local and regional health authorities were given greater financial responsibility. Competition and decentralization were the major themes of the reforms initiated.

In 1994 President Clinton, under fierce attack from his political opponents as well as powerful pressure groups, had to withdraw his reform proposal for US healthcare. Several of the European health reforms had also run out of steam. Disillusion was growing as the superficial nature and limited effectiveness of those mostly administrative efforts to promote change were demonstrated (1). Faced with a financial crisis, healthcare leaders in many countries had to return to less sophisticated cost-cutting. The European reform agenda in the mid-1990s was cited as one confronting resource scarcity, trying to achieve equitable funding, allocating resources effectively and delivering services efficiently (2).

Lately, the health policy debate has seen the return of the 'old menaces': long waiting lists and times, crowded institutions, complaints about poor service, and increasing concerns about costs. These have been the issues raised both by decision-makers and by the public, and extensively covered by the mass media. Health professionals have started publicly to criticize their current working conditions, and reports on overworked staff and fears of deteriorating quality are frequent. Recently, several well-known clinical leaders in Sweden have left their managerial posts, announcing that they cannot take responsibility for the service, and that overly tight resource constraints conflict with their ethical obligations.

Are those alarming reports and protests by health workers a backlash of the reforms or a symptom of more fundamental challenges in healthcare, not amenable to quick-fix reforms? It seems to me that that a broad agenda of analysis is more worthwhile than a more limited attempt to identify the consequences of the reforms. To isolate the reforms from the complexities of healthcare systems, which are influenced by a variety of driving forces, is a questionable evaluation exercise. The reforms need to be put into a perspective.

The aim of this article is to assess the ethical implications of recent changes in healthcare, starting with the reforms of the early 1990s. Structural changes receive special attention. Common ethical principles are used as an assessment instrument, and results are interpreted within a framework of health policy decision-making. Af-

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ter defining health reforms and citing the ethical principles, these are applied, first, to the systems level, second, to the organization level, and, finally, to the practical reality of cost containment. The discussion refers to lessons from organizational theory, and we conclude by revisiting the ethical foundations of healthcare.

WHAT ARE STRUCTURAL REFORMS IN HEALTHCARE?

Mills defines health reforms in terms of the specific policies involved, and distinguishes between

1. bureaucratic, and
2. market varieties (3).

The first type can be further subdivided into

1.1. Structural changes (e.g. the establishment of new authorities and decentralization).
1.2. Financing.
1.3. Policy process improvements (e.g. methods for service package selection) and
1.4. Improvements in management (e.g. greater autonomy for healthcare organization).

Market-oriented reforms seek to introduce market pressure by

2.1. Creating an internal market for the public providers, or
2.2. Allowing private entrepreneurs to enter the market.

Competitive arrangements include providers only or both purchasers and providers.

A restriction of 'structural' to include solely the arrangement of physical resources or organization would cover area 1.1 only. Physical resources, though, depend on funding, and funding mechanisms are closely related to other forms of governance and control.

Bergman defines structure as 'the framework which is formed by the way in which different functions are handled', and includes in structure quantitative factors (physical resources) and qualitative relations (the cooperation between actors and division of work, based on specialization and the differentiation of services) (4). He proposes that a structural change is a reaction to other more fundamental changes, and makes an illustration of the relations as in Fig. 1.

I discuss reforms and ethics in two stages. The start will be an analysis of the *systemic* level (5), covering institutional arrangements, governance and control. This is followed-up by focusing specifically on changes made in *organizational structures*.

ETHICAL PRINCIPLES

I will perform the assessment by comparing to what extent the changes are in harmony or in conflict with basic ethical principles, which are familiar from the ethical codes of health professionals. Interestingly enough, they also form the basis of the charters of the colleges of health service administrators and managers (6).

The principles are those of

- non-maleficence;
- beneficence;
- autonomy;
- justice.

The ethical principles are analogous to many health policy goals. Healthcare is organized as a professional service with practice licensed and strictly controlled in order to secure beneficence and non-maleficence. The integrity and autonomy of the patient are also in many countries protected by legislation or, at least, by common law. Equity in terms of equal access to care regardless of non-medical factors, as well as care provided based on need are important expressions of the societal aspiration for a just healthcare system.

HEALTHCARE SYSTEMS REFORMS

A recent comparison of health reforms in predominantly publicly funded systems finds the same kind of goals related to the reform initiatives across countries. Those are: to achieve a more efficient way of allocating resources than presently, to increase responsiveness to consumer preferences, and, while striving for the realization of those goals, to maintain equity (7). The following general trends, characteristic of the reforms studied, were found:

- towards universal mandatory health insurance;
- towards contracts as the main form for control of healthcare providers;
- towards increasing competition between providers;
- towards strengthening primary care.

A summary of the trends cited in relation to ethical principles is presented in Table 1. Universal coverage is obviously not in conflict with any of the ethical principles. In theory one might imagine a too abundant supply of services to lead to an unhealthy overconsumption of services, but no coverage will be unlimited. Justice prescribes the ways in which the coverage has to be funded in order to be equitable.

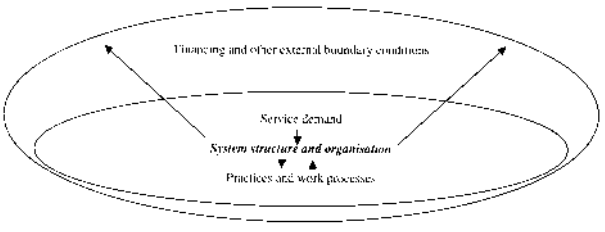

Fig. 1. Structure in relation to other parts of the healthcare system.

Table 1

Consequence analysis: systemic reform trends

Reform issue	Non-maleficence	Beneficence	Autonomy	Justice
Universal coverage	+	+	+	+
Contracting	+	+	?	+
Competition	?	+	+	?
Primary care	+	+	+	+

+ Issue in harmony with ethical principle.
? Unclear position.

A contractual relationship between a purchaser (a health authority or health plan) and a service provider has several benefits over the reimbursement of separate service items or a global budget allocation. The purchaser negotiates with the provider(s) on behalf of the patient or out of a responsibility for the population it serves. The purchaser can require quality guarantees (non-maleficence), services provided according to need (beneficence) and decide on terms, which are just to all covered. The negotiation process is thought to lead to a limited number of providers being granted contracts, which possibly reduces the freedom of choice for the patient (autonomy).

Regulated competition is expected to lead to higher service quality (beneficence) and a wider choice for the patients. A fierce competition on price only might compromise quality (non-maleficence), thus there is a need for control by regulatory authorities. Competitive mechanisms in healthcare run the risk of promoting the opportunistic behaviour of providers, (resulting in 'cream-skimming' and adverse selection), contrary to health policy goals, as recently reiterated by Evans (8). Hunter adds another caveat by stating that public regulatory mechanisms are weak and defective, and hence that the production of public goods should stay within the public sector (1).

A shift of focus from hospital to community-based primary care increases service provision in the local environment, adds to the choice of patients and does not compromise quality when adequately organized and funded. Primary care is a local service and increases equal access.

MEASURES AIMED AT CHANGING ORGANIZATIONAL STRUCTURE

In recent years there has been frequent 'restructuring' of health service providers. There has so far been little systematic assessment of to what extent those have been influenced or initiated by systems-level reforms. In Sweden and Finland those interventions into the production of services have been made with the active support of political decision-makers. One possible interpretation is that as the indirect control by internal markets, introduced as a part of the systems-level reforms, did not achieve the required efficiency goals, direct control was reintroduced.

The recent review by Bergman et al. (4) of Swedish counties describes the different strategies used when intervening in the organizational structure of healthcare providers. These can be categorized into three broad classes:

- reduction of in-hospital capacity and acute care services
- hospital mergers and changed division of work between hospitals and parts of hospitals
- transfer of services to ambulatory care settings.

The rationale behind these measures has not been as intensely discussed as the pros and cons of market orientation in the early 1990s. A reduction in capacity is intended to beat 'Roemer's law', i.e. the tendency of the demand for services to closely follow supply. In addition, the goal is to avoid duplication of services and to try to capitalize on both the economies of scale and scope. The literature in the field does still not give much guidance on whether there is any substance in those hopes. A study from England found that cost and activity comparisons across hospitals are difficult to make and interpret, but it concludes that neither economies of scale nor scope can be expected to be present in the same way as in industrial production (9). Two literature reviews found no evidence to show that a consolidation of in-hospital and acute care would lead to lower unit costs (10, 11). A study on Swedish hospitals was non-conclusive, too (12). Although there is a positive correlation between workload and outcome (even demonstrating threshold values) especially of a single professional, the result cannot be extrapolated to indicate overall differences in quality between large and small institutions (13).

The internal reorganization of service production as well as the transfer of services to ambulatory care settings is inspired by quality and process management (14). 'Seamless' or 'shared care' (Britain) and streamlined 'chains of care' (Sweden) are believed to lead to a less resource-intensive use of services. There is still a lack of comprehensive assessments of the effects on quality, service and costs of these organizational changes.

Although the driving force behind the restructuring in almost all the cases has been cost containment (4), the measures are also a result of demographic and technologi-

cal changes. The greying of the population calls for local, primary and community-care-based services, and the advances in medical technology support the transfer of technology and care of even very ill patients to ambulatory and home care.

The Swedish experience was that local services, indeed, did improve, but that the population had to travel longer distances for specialized services than previously. The clearly stated goals to lower costs and raise efficiency led to an increasing pressure on the staff. Opinions were expressed that cost-cutting had been brought to its limit (4).

An analysis of the ethical consequences of the organizational changes is much more difficult to carry out than an analysis of the systemic reform trends (see Table 2).

The reduction of in-hospital services potentially decreases access, but might be well compensated by substituting service supply provided in other form of care. In terms of beneficence the action is neutral, on the condition that the total amount of care corresponds to population needs. The longer distances to specialized care might create unequal access on a geographical basis and limit choice.

Hospital mergers consolidate the professional expertise and experience of the staffs and are not in conflict with the ethical principles, except autonomy. Reducing the duplication of services will limit the choice for patients.

The transfer of services to ambulatory care settings in the local environment of patients strengthens the position of the patients in every respect.

In summary, there seem to be few ethical caveats when analysing the presuppositions, beliefs and goals of healthcare reform both on the systemic and organizational level. The single biggest threat to a healthcare system in congruence with basic ethical values in healthcare is lack of universal coverage. To provide that coverage was, indeed, one of the cited healthcare reform trends. Doubts have also been expressed concerning the blessing of competition. Structural change within healthcare organizations might mean a reduction of patient choice (autonomy), but otherwise localized and customized services should work to the benefit of patients. These conclusions, though, are drawn from an analysis of the *intentions* of reforms, and are based on evidence of actual implementation only in a limited number of cases. It is therefore necessary also to examine the current reality.

Indeed, one gets a much gloomier picture when reading the abundant stream of anecdotal evidence from both the press, patient complaints and alarming reports on burned-out healthcare staff. The overriding theme is mere *cost-cutting* rather than ambitious reform. Expenditure reduction measures are still very frequent in many publicly organized health services as governments struggle to balance their economies in the aftermath of the recession of the early 1990s. Reform or no reform, that is, the everyday reality poses important managerial and ethical challenges to decision-makers.

THE ETHICS OF COST-CUTTING

Healthcare expenditure can be influenced by reducing either demand or supply. Of the *demand* measures, a reduction in 'insurance' coverage is not on the reform agenda. In many countries cost-sharing initiatives have increased the out-of-pocket payments for households. Those are a threat to equity and an ethical dilemma, in conflict with the principle of justice, but are revenue-generating, not cost-cutting measures, and thus outside the scope of this presentation. Health promotion and disease prevention are strategies that are worthwhile and desirable, on the condition that they do not generate cost-ineffective programmes.

Reductions in the cost of service *supply* might be achieved by one of three ways, as adopted from Øvretveit (15):

- restricting access;
- rationing based on a systematic method;
- developing the process of care to increase cost-efficiency.

Restricting access by reducing capacity is a crude method, where waiting lists are allowed to grow and no programmes for handling the unmet demand have been designed. Rationing can in principle take two forms. The first is to exclude non-effective interventions and treat-

Table 2

Consequence analysis: changes in organizational structures

Reform issue	Non-maleficence	Beneficence	Autonomy	Justice
Reduction of in-hospital services	+	0	?	?
Hospital mergers	+	+	–	+
Transfer of services to ambulatory settings	+	+	+	+

+ Issue in harmony with ethical principle.
– Issue in conflict with ethical principle.
0 Issue neutral in relation to ethical principle.
? Unclear position.

Table 3

Consequence analysis: cost-cutting strategies

Reform issue	Non-maleficence	Beneficence	Autonomy	Justice
Restricting access	?	–	–	?
Excluding non-effective treatment	+	+	+	+
Prioritising	?	+	–	+
Developing the process of care	+	+	?	+

+ Issue in harmony with ethical principle.
– Issue in conflict with ethical principle.
0 Issue neutral in relation to ethical principle.
? Unclear position.

ments defined as non-medical (e.g. cosmetic surgery). The second is to prioritize patients and their urgency of care according to their need and the potential outcome of the treatment.

How are these measures consistent with the ethical principles (Table 3)?

To restrict access does not add to patient benefit; on the contrary, it might deprive patients of much needed care, it limits their choice and risks unjust treatment of patients in the absence of clear guidelines. Excluding non-efficient treatment, on the other hand, is highly desirable and consistent with all four ethical principles. The difficulty in assessing the effectiveness of treatment is not dealt with in this context.

Prioritizing might carry the risk of excluding from treatment those patients who could benefit from it. This is a function of the total number of resources available rather than the decision rule itself. Although prioritizing does reduce the choice of patients, it is just in that decisions are made on needs and efficiency grounds only.

To 'streamline' the process of care by reducing 'unnecessary' or wasteful elements is unproblematic from a non-maleficence and beneficence standpoint. It is just in that it treats patients equally, based on medical condition. The same is true of measures to reduce practice pattern variation and to adhere to professionally sound guidelines. It does reduce the choice of patients, although from a professional point of view in their best interests.

Adjusting to existing resources—regardless of whether limited because of natural restrictions such as availability of professional personnel or politically decided budget allocations—is unavoidable, and rationing is not unethical but a 'rational approach' to resource allocation (16). It is well guided by the ethical principles applied to this analysis. The most recent edition of the Ethics Manual of the American Medical Association 'asks physicians to be responsible stewards of pooled resources' (17).

FIRM ON PRINCIPLE, SLOW TO CHANGE

Two important features of national healthcare systems need to be highlighted in this context. First, the resources devoted to healthcare are closely related to the nation's wealth, e.g. calculated as gross domestic product (GDP). Almost 90% of the variation in healthcare costs is explained by GDP. As the national wealth grows, so do healthcare costs, at a pace which exceeds annual economic growth by 30% (18). The economy of healthcare demonstrates an astonishing *stability*. Second, decisions regarding health and healthcare involve a great number of stakeholders. Decision-making in healthcare is *incrementalist* in nature (19). Decisions are formed in an intricate process where actors promoting their interests seek power bases and form alliances, the result being compromises, piecemeal and marginal changes rather than comprehensive measures or radical change.

If we apply the following framework of policy design and political feasibility (Fig. 2) it might help us to understand the mechanisms behind decision-making in healthcare. It distinguishes between the 'costs' and 'benefits' of decisions, and classifies those as being either 'concentrated' (well focused) or 'diffuse' (20).

The cost-cutting agenda has very concrete and concentrated political costs in terms of service level reduction and unpopularity among both patients and healthcare personnel. The benefits are diffuse, at best a balance in the budget in the years to come. According to the framework, cost-cutting is politically infeasible and calls for 'entrepreneurial politics', 'will and leadership' (21) or the 'conviction politics' of Margaret Thatcher. As the last example shows, it requires exceptional political leadership and a monolithic decision structure to have an impact. Cost-cutting as a political endeavour is not everybody's favourite and has little chance of being elevated to a political programme.

Examples from the USA indicate that elected officials need to show an exceptional involvement in planning and policy design in order to be successful in reforming healthcare. A necessary condition is, in addition, that earlier incremental actions have laid the ground for the more far-reaching change (20). The case of Israel shows that powerful actors block reform when their interests are threatened, regardless of its merits (21), and the case of The Netherlands that such 'corporatism' eventually forces the government to tighten its grip (22).

COSTS		
Diffuse	CLIENT POLITICS Politically attractive	MAJORITARIAN POLITICS
Concentrated	INTEREST GROUP POLITICS	ENTREPENEURIAL POLITICS Politically infeasible
	Concentrated	Diffuse
	BENEFITS	

Fig. 2. Analysis of policy design and political feasibility.

Health policy incrementalism means that dramatic changes are rare and that the system is characterized by stability. Unpopular decisions are difficult to make and even more difficult to implement. The systems issues are intermingled, and even the consequences of decisions that have only a marginal effect are difficult to predict. The system shows a striking *robustness*, though, owing to its very complexity. The care processes are formed by a myriad of decisions, made first and foremost by professionals and caregivers. The small steps can be corrected if errors occur. The decisions are guided by a balance of professionalism, self-interest and ethical principles. This kind of decision-making forms the backbone of the system, determining the final outcome of policies, structures and management actions. This is left when those other layers are 'sliced' away, referring to a metaphor for indiscriminate cost-cutting, used in the Nordic countries.

It is important for the sake of the legitimacy of the healthcare system that political decisions are based on broad popular support and that they are in line with the moral values of the population. More important, though, is that the health professionals have got the balance right and act according to their professional ethics and standards. Their codes of ethics include an obligation to take responsibility not only for the individual patient but also for the population as a whole, and to use resources wisely, even to engage in improvement efforts in order to increase the quality of the service (19). As long as the politicians remember that the system relies on the moral integrity of the health professionals, and avoid creating rules or incentive systems which carry the risk of eroding that integrity, healthcare will probably succeed in protecting its basic values and coping even with outbreaks of financial crisis.

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